TEXAS TECHNOLOGICAL COLLEGE

A CHILDREN'S PSYCHIATRIC CLINIC

AND

RESIDENTIAL TREATMENT CENTER

by

James R. Rittenberry

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HISTORY
OF
PSYCHIATRIC CLINICS FOR CHILDREN

There appears to have been three lines of development in the evolution of Psychiatric Clinics for Children: the early development in state hospitals and schools for the feeble-minded; the development of clinics for juvenile deliquents; demonstration child guidance clinics.[1]

The developments in state hospitals and schools for the feeble-minded can be grouped together because at this time little distinction was made between the feeble-minded children and those otherwise maladjusted.

Adolf Meyer, known as the Dean of American Psychiatry and the original source of inspiration to many workers in the field of child psychiatry, pointed out that psychiatrists in the latter part of the Nineteenth Century were chiefly concerned with problems of neuropathology and the

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[1]Helen Leland Witmer, Ph.D. Psychiatric Clinics for Children, (New York: The Commonwealth Fund: London: Oxford University Press; 1940), p. 41.

classification of mental diseases.[2] (Webster defines neuropathology as "the study of an abnormal condition of the nervous system or of a nerve."[3] At this same time there began to be evidence of some interest shown in preventive work. Books and articles were being written on the subject of mental hygiene as early as 1843. In the year to follow, dispensaries and clinics for mental patients slowly began to appear. The earliest of which was established by Dr. John B. Chapin in the Pennsylvania General Hospital in 1885. This was soon followed by a dispensary and clinic in the Warren (Pennsylvania) State Hospital.[4]

The Pennsylvania Hospital Clinic stated as its purpose the "treatment of mental diseases in their early or incipient stages occurring among the poor and indigent."[5]

In 1871, the California State Board of Health proposed the erection of a psychopathic hospital for the

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[2]Ibid., p. 41.

[3]Webster; New World Dictionary of the American Language: (Cleveland, New York: The World Publishing Company).

[4]Cited by Albert Deuctsch, The Mentally Ill in America; (New York: Doubleday, Doran & Co., 1937), p. 296.

[5]Witner; op. cit., p. 42.

treatment of incipient mental disorders, because it was believed that much permanent insanity was due to the lack of early care.[6]

The first clinic to be credited for marking the beginning of clinical work with children was called the Boston Dispensary, which opened in 1897, under the direction of Dr. Walter Channing.[7] Dr. Channing wrote in 1901, "A mental clinic should strive to investigate a few cases thoroughly....and a good deal of time should be spent on the consideration of sociological factors."[8]

Through the influence of Meyer, other state hospitals in New York and Massachusetts began to offer clinic services. The St. Lawrence (New York) State Hospital opened in 1909, an outpatient clinic and Northampton (Massachusetts) State Hospital followed. In 1914, the Massachusetts State Board of Insanity suggested that each hospital serve as a mental health center for its district.

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[6]Deuctsch; op. cit., p. 309.

[7]Witner; op. cit., p. 42.

[8]Quoted by E. Stanley Abbot; "Out-Patient or Dispensary Clinics for Mental Cases"; American Journal of Insanity; LXXVII (1920), p. 219.

With a shift of psychiatry to an interest in total behavior and in the social and emotional genesis of mental disorders, it was a natural step for clinics to aid children who were socially maladjusted.[9] Adolf Meyer had suggested by his writings of the possibility of doing preventive work by treating children who exhibited "traits of character that should serve as warnings to be heeded."[10]

The first mental hospital to study many children seems to have been the out-patient department of the Boston Psychopathic Hospital which opened in 1912 under the direction of Dr. E. E. Southard. Its out-patient children were referred by schools, courts, and social agencies.

Generally, State Hospital Clinics rarely accepted children as patients before about 1920. Another which did was the Allentown State Hospital in Easton, Pennsylvania in 1915. With this hospital the beginnings were made to separate the feeble-minded and to treat them as a separate problem from those children needing psychiatric help. In 1919,

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[9]Witner; op. cit., p. 44.

[10]Witner; op. cit., p. 44.

the state of New York, set up "school clinics" as an outgrowth of the Massachusetts School for the Feeble-minded. According to law, children three or four or more years retarded in school must be examined by such clinics.

The second line of development of psychiatric clinics for children was the appearance of clinics for juvenile delinquents.

In 1909, Dr. William Healy, in connection with the Juvenile Court of Cook County, Illinois, prepared a five-year study of juvenile offenders and provided the pattern on which later child guidance clinics were partially modeled. The first clinic of this nature was called the Juvenile Psychopathic Institute and later called the Institute for Juvenile Research.[11]

The chief influence of this project was the fact that it brought to the study of delinquency the idea that the child is "the product of conditions and forces which have been actively forming him from the earliest moment of unicellular life."[12] Dr. Healy met each child as an individual

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[11]Ibid., p. 47.

[12]William Healy; The Individual Deliquent, Boston; Little, Brown & Co., 1915, p. 28.

and data concerning the child's personal history and social experiences were secured from the probation officers. The assembling of this data is now done by social workers and this method of studying the delinquent is now a standard practice in child guidance work.

A similar program was undertaken by Ohio in 1915, with the establishment of the Ohio Bureau of Juvenile Research. This Bureau was made a division of the State Department of Public Welfare and so set up a precedent for direct state responsibility in the area of psychiatric and psychological problems of children. Its purpose was that of investigating the causes and motives of juvenile misconduct and working for their correction. The Bureau believed that delinquency and crime were largely the expression of "defective or deranged minds," and could be attacked best through the treatment of juvenile offenders.[13]

In 1916, the problem of delinquency reached Dr. George F. Inch of the Kalamazoo State Hospital and he persuaded the Grand Rapids Probate Court to send children to the clinic and pay their expenses. This plan was taken up by

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[13]Witner; op. cit., p. 48.

other hospitals, but never amounted to much beyond that of a diagnostic service.

The third line of development in Children's Psychiatric Clinics, was the demonstration child guidance clinics, which were being planned by the National Committee for Mental Hygiene, around 1921. The first program was designed to demonstrate a method of checking juvenile delinquency and was financed by the Commonwealth Fund. Its purpose was to spread an adequate understanding and treatment of the personality difficulties of children which lead to juvenile delinquency or unhappiness and failure in adult life.

Through the influence and experience of the Illinois Institute for Juvenile Research and the Judge Baker Foundation, the program consisted of a psychiatrist and a psychologist working through the juvenile court. Afterwards, the psychiatric social worker was added to the clinical staff by the Boston Psychopathic Hospital and the Henry Phipps Psychiatric Clinic, both who differed from the Institute also in serving the whole community rather than merely the court.[14]

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[14]Ibid., p. 51.

In 1922, St. Louis and Norfolk set up the demonstration clinics. These were set up for the purpose of,

> showing the juvenile courts and child-caring agencies what psychiatry, psychology, and social work have to offer in connection with the treatment of the "problem child", and by properly directed and effective methods of treatment not only to help the individual delinquent to a more promising career but... to decrease the amount of delinquencies.[15]

Later the disadvantages of working wholly through courts appeared and the most effective preventive work was being done with children whose misconduct had not yet caused them to become juvenile delinquents. Clinics began to appear which were connected with hospitals, schools, and referrals from parents, teachers, and social workers were considered.

After two or three years experience with these child guidance clinics, it was discovered that psychiatric help was not the only factor in helping the children. It was found that these clinics could not work apart from the community, as they had been and that they must depend upon other social agencies and institutions for assistance in determining their conclusions about a child. Without these resources, plans for environmental treatment could not be carried out

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[15]Lawson G. Lowery; "The Child Guidance Clinic", Childhood Education, Vol. 1, (1924), p. 100.

effectively, nor could psychotherapy compensate for gross defects in the community situation.[16]

The experience gained from the early child guidance clinics formed the present day model operation on which today's clinics are based. A typical clinical staff consists of psychiatrists, psychologists, and psychiatric social workers in the ratio of 1:1:2 or 3.[17]

A clinic of this type holds as its objective, "bettering the adjustment of children to their immediate environment, with special reference to their emotional and social relationships, to the end that they may be free to develop to the limit of their individual capacities for well-balanced maturity."[18]

Today's clinics are interested in helping children with their present problems for the sake of present satisfactions.

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[16]Witner; op. cit., p. 53.

[17]Ibid., p. 54.

[18]George S. Stevenson & Geddes Smith; Child Guidance Clinics; A Quarter Century of Development, New York, The Commonwealth Fund, 1934, p. 55.

Such clinics receive their patients from the medium of social agencies (including courts and schools) and directly from parents.

There is considerable diversity among clinics, much of which is traceable to the theories of psychiatry under which they serve. Other differences among clinics derive from the auspices under which they are conducted, the geographical areas in which they operate, the training and interest of the staff members, and other factors of less general importance.

PURPOSE

There once was a time when children with emotional disturbances were ignored, rejected, misunderstood and given little if any help toward recovery. Today, in our modern, enlightened and industrialized society, children with emotional disturbances are ignored, rejected, misunderstood and given little if any help toward recovery.[1]

In recent years a more helpful outlook for the emotionally disturbed child has been created, because of an increasing interest in the field of mental health. The council for children with Behavioral Disorders and the Institute on Child Health and Human Development within the National Institute of Health have been founded because of this interest.

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[1]Paul W. Penningroth, Ph.D.; A Study of Programs for Emotionally Disturbed Children in Selected European Countries, U. S. Department of Health, Education and Welfare, Maryland, 1963, p. 1.

Many states have declared that the planning of children's facilities will be one of their chief problem areas as they develop their comprehensive state mental health plans.

The National Institute of Mental Health is increasing its activities for disturbed children. Child psychiatry became a separate specialty when certification began in 1959. The need for children psychiatric facilities, is evident when we realize the heavy percentage of children that are effected.

"Surveys tell us that from 7 to 20 per cent of all children are emotionally disturbed.[2]

The purpose of this thesis is to examine the relationship of architecture and psychiatry, and to design a social environment for the treatment of children with emotional conflicts. The design problem, says Dr. Humphry Osmond, (Psychiatrist and Director of Research in Neurology and Psychiatry for the State of New Jersey) calls for an architect who is deeply aware of the patient's experience and one who can design a building which limits social interaction to

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[2]Ibid., p. 1.

that amount which provides the least chance for panic and withdrawal, while maintaining the greatest and most suitable kind of social relationship.[3]

Dr. Osmond also states certain factors which could be harmful or helpful in their environment for the mentally ill:

> Avoid anything which makes heavy demands on the patient's impaired perceptive apparatus. Avoid ambiguous and muddled design, too much complication, even though it may be aesthetically interesting. Avoid too much space, and too many people impinging on the sick person. Insure that shapes, color, lighting, fixtures are unambiguous, that corridors and spaces are clearly defined, that living space of the biologically derived kind is provided.[4]

Many times the question has been asked, does physical environment make or have any real contribution to the treatment of the mentally ill? We must assume that it does as many doctors have agreed that psychotherapy can be done anywhere, but the correct physical environment can speed up "reaching" the patient. The question that has no answer is how much importance to the ill the environment has to offer.

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[3]"The Psychological Dimension of Architectural Space", Progressive Architecture, (Philip H. Hubbard, Jr., April 1965), p. 160.

[4]Ibid., p. 160.

Doctors' opinions differ very much to this question of importance and only after an architectural environment has been applied and the results taken over and compared to the past can we make an intelligent answer. We must think of Dr. Osmond's advice, "No building is ever perfect, but we can at least avoid the mistakes which have been repeated ad nauseum all over the world. Let us try to make some really original mistakes of our own. We may find they don't work too badly."[5]

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[5] Ibid., p. 160.

TYPES OF CHILDREN

Psychiatrists in recent years have said that they need institutions which are not institutional, but are homelike. To say this is to state the problem, not give the solution.

> Within the dictum of adherence to human scale and basic human needs for quiet, privacy, fresh air, natural light, color, texture, and all those qualities of environment that make life more meaningful, the design itself must deal with the particulars of very special populations.[1]

With this in mind, the following is a classification of the various emotional conflicts of children who will be the residents of the proposed clinic and residential center. These children demonstrate their inner disturbances in a variety of ways: some withdraw into a world of their own, responding little if at all to those around them; some become delinquent and antisocial, seemingly in constant attack on the surrounding environment; others are so traught

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[1]"Mental Hospitals" Architectural Record, Nov., 1963, Eugene E. Weyeneth.

with fears and anxieties that everything seems threatening to them. Many of these children, in spite of adequate intelligence, have difficulty in school, behaving poorly and being unable to succeed.

As a guide to the classification of these children and their emotional problems, the following is a basic description of typical conflicts found in children deemed suitable for psychiatric need. The information given here is derived from the book, Treatment of the Child in Emotional Conflicts[2], and the residential housing of the center will be designed with these children in mind.

Mr. Hyman S. Lippman, in his book, Treatment of the Child in Emotional Conflict, has narrowed the emotional conflicts of children into four major classifications: the neurotic child; personality problems; the child who acts out; the child with a tenuous hold on reality.[3]

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[2]Hyman S. Lippman, M.D. Treatment of the Child in Emotional Conflict; (McGraw-Hill Book Co., Inc; New York, Toronto, London, 1956).

[3]Ibid.

Neurotic Child

I. The child in acute anxiety states:

A. Generalized neurotic inhibitions
B. Hysterical anxiety manifested by phobias and attacks of acute anxiety
C. Psychomatic reactions to tension
D. Attacks of anxiety may occur at any age, but are frequently during the prepubertal and pubertal periods of development, between 10 and 15 years of age.

II. The child with school phobia:

State of acute anxiety about going to school. "Phobia" suggests a localized or circumscribed anxiety related about other activities.

III. The child with depression:

A. The child is usually active and able to maintain an interest in his activities even while depressed.
B. Feeling unloved is chief cause of neurotic depression in children.
C. Primary feelings of a depressed child are unhappiness and dejection.
D. A characteristic of neurotic depression in children is a deep feeling of self-reproach and unworthiness that resembles the depression of adults.

IV. The child with obsessional neurosis:

A. The child has ceremonials or rituals which he cannot control. He is obsessed by the need to repeat acts over and over again. He is totally unaware of why he behaves in this manner.
B. Takes residential treatment
C. Treatment takes time.

Personality Problems

I. The withdrawn child:

A. A child withdraws from other children and adults to seek safety.
B. Actual or fantasied demands made on him by other people stir up discomfort or anxiety.
C. Group therapy is the method used to help the withdrawn children learn that the other children are friendly and safe. The group should be small and include children who are not aggressive or destructive.

II. The overprotected child:

A. Does not present disturbing behavior to his environment.
B. His dependency on his mother prevents his making contacts with other children.
C. Problem is adjustment
D. He feels different and isolated, and resents his mother whom he blames for his unhappiness.

III. The effeminate boy:

A. Feels out of place with boys.
B. Unable to accept himself because his behavior is unacceptable to his parents.
C. Most difficult problems arise when parents become overconcerned.
D. Effeminacy is not synonymous with homosexuality.

IV. The narcissistic child:

A. A neurotic child's narcissism makes him seek excessive amounts of interest concern for his own personal emotional needs.

B. The autistic child (absorption in phantasy to the exclusion of interest in reality) does not dare invest his libido in others and remains narcissistic. libido--energy, motive, force, desire, or striving, either as derived from the sex instinct or from primal urge to live.

V. The child with neurotic character:

A. A neurotic individual who has internalized his conflicts, but expresses them in general personality traits rather than neurotic symptoms.
B. May show evidence of unconscious guilt feeling and a deep need to be punished but does not have the rituals of the obsessional neurotic.
   1. The child with hysterical character; tends to be infantile, overemotional, highty, impulsive, self-deceptive, histrionic, and dishonest; tends to be passionate in likes and dislikes; over demanding of affection.
   2. The child with obsessional character: their outstanding characteristic was marked by stubborness and inability to accept opinions different from their own. They are industrious and perfectionistic in school work. They tend to mix poorly with children, not because of a narcissistic withdrawal, but because they do not seem interested in relating to others.

The Child Who Acts Out

The term acting out denotes aggressive behavior which expresses fantasy or wish. The person does not know what his behavior means.

In therapeutic work with emotionally conflicted children, play therapy represents a form of the child's acting out his unconscious thoughts and feelings through the play characters. By translating this play activity back into the thoughts which the child is expressing, the therapist learns to understand the child better and explain his feelings.

I. The unsocialized child:

A. Children not wanted or needed in their homes.
B. Distrust in adults.

II. The neurotic character:

A. Children may manifest the behavior of the neurotic character by living active, aggressive lives which keep them just outside of danger. Their hostility is not related primarily to others; others are hurt by their actions more by accident than design.
B. A child with neurotic character may act out his neurotic conflict aggressively also by teasing and annoying other children or quarreling with them.

III. The neurotic delinquent:

The essential feature of neurotic delinquency is that it represents behavior directed against society to express neurotic conflict.

Freud demonstrated that people with deep unconscious guilt derived from incestuous conflict commit delinquent acts with the intention-unknown to them-of being apprehended for punishment. The suffering from their delinquent act satisfies their need to be punished.

IV. The "psychopath":

A. The most pathologic kind of acting out.
B. Sumptoms: chronic aggressive, uninhibited behavior, which tends to respond to the most intensive therapies, failure to benefit from previous experience of recognizable feelings of guilt.
C. A general superficiality in thinking and judgment. The psychopath lives for the moment, disregards the future, constantly seeks gratification, and refuses to tolerate frustration.
D. He lacks loyalty to friends.
E. He often suffers from acute anxiety.

The Child with a Tenuous Hold on Reality

I. The psychotic child:

   A. Anxiety is a prominent symptom.
   B. Child's dependency may be so extreme that he cannot tolerate any separation from his mother.
   C. Some hold an extremely weak hold on reality; the outer world seems to mean little to them except as a possible source of danger.

II. The markedly unstable child:

   A. Poor hold on reality, though at no time is their contact with reality entirely lost.
   B. Not psychotic; not neurotic.
   C. Spend time on details in drawing, games.
   D. Slow in grasping cause and effect relationships.
   E. Parental rejection--insecurity.

III. The child with organic brain damage:

   A. Bizarre behavior
   B. His hold on reality may be threatened or lost.

IV. The child who withdraws into convulsive seizures:

   A. Epileptic
   B. May be attempting an escape.
   C. Organic damage--chemically or physically induced.

Because of the need of special attention, the residential facility will exclude certain children. The institution will not accept children for custodial care, or children sent by court order. The willingness of the parents must accompany the child through treatment. Others excluded will be children with acute or chronic physical illnesses or

those requiring bed care. Children whose behavior is so bizarre that the need for psychiatric hospitalization and those children deemed only mentally retarded will also be excluded. Adequate hospitals and a center for mentally retarded children will be on the adjoining medical unit.

PSYCHIATRIC SERVICES

The clinical staff of a children's psychiatric clinic consists of psychiatrists, psychologists, and psychiatric social workers, who work in close coordination and collaboration. This collaboration among the members of the professional personnel is an essential component of psychiatric service to the child.

The child psychiatrist, who is the main member of the psychiatric team, is well trained and educated in his field and is licensed for the diagnosis and treatment of psychiatric disabilities in children. As a clinical specialist, the child psychiatrist utilizes his basic diagnostic and therapeutic skills in the important function of consultation with other medical specialists, general physicians, non-medical child care personnel and teachers.[1]

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[1]"Planning Psychiatric Services for Children", (American Psychiatric Association; Washington, D. C., 1964), p. 15.

The child psychiatrist is also concerned with administration. He is responsible medically and legally for patient care and may provide leadership in planning overall policy, in coordinating clinical services, and in community relationships.

The second member of the psychiatric team is the child psychologist. He is trained to offer diagnostic evaluation of a child's intellectual and personality functioning, through the use of specific tests designed to further such evaluation.[2] The psychologist is also included in offering psychotherapy to children and parents in much the same way as the child psychiatrist.

The child psychiatric social worker has a special area of skills and knowledge which related particularly to the social phenomena in interpersonal relationships within the family and within the community.[3] The social worker is competent in working with parents on their children's problems and some, with the appropriate training, are able to do psychotherapeutic work with children.

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[2] Ibid., p. 16.

[3] Ibid., p. 16.

In connection with this basic team, there are many others working closely together to achieve the same aim. Among them are psychiatric and public health nurses, teachers, occupational therapists, and child care workers and volunteers.

A range of working relationships exists, with varying team composition and varying responsibilities of one or another team member. All those concerned work together for the common ultimate goal--the maximum possible prevention of psychiatric disabilities in children.

PROGRAMS OF TREATMENT

There are three main programs of treatment called for in a children's clinic and residential treatment center. The first is an out-patient service which is for children whose emotional conflict is of such a degree that he needs psychiatric help, but does not require him to leave his family. Depending upon the needs, he will visit the clinic weekly for interviews by a psychiatrist, a psychologist, or more experienced social workers. Parents would be seen individually or in groups by social workers. The patients would be limited to those up to the age of 15 years.

The second program of treatment is the day-treatment service. This treatment is for those children who need more varied treatment approaches than can be provided in the out-patient clinic but do not require residential treatment. The children come to the clinic each day for a period from half a day to a full day. Emotional problems of the type requiring this kind of program are usually rooted in the inter-relationships between the parents and the child. Just as in the out-

patients program, parents are seen for weekly interviews by a psychiatrist, psychologist and social workers.

The third program offered is the residential treatment program. Here the child remains in residence for anywhere from 6 months to an average stay of two years. The residential treatment program is a relatively new addition to the services offered to the troubled child. Many aspects of this type of facility are still being observed and exaluated as to their success or failure. However, there is a shortage of the type and the waiting lists for those existing are enormous.

PLAY-THERAPY

Play-therapy is the preferential treatment for many young children and should be used extensively in child guidance. However, group therapy is no substitute for individual treatment; it is beneficial only in specific cases, which must be carefully selected and grouped. When children are assigned to groups haphazardly, the method is not only ineffective, but may actually be harmful.[1]

Children suitable for play-therapy groups are those who have a capacity for social hunger. A brief description and classification of these children is given in the following outline.[2]

Children Suitable for Play-Therapy

I. Withdrawn children:

A. Social isolation

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[1]Haim G. Ginott; Group Psychotherapy with Children, The Theory and Practice of Play-Therapy; (McGraw-Hill Book Company, Inc. New York, Toronto, London, 1961).

[2]Ibid., p. 18.

B. Opportunity for free and safe interpersonal communication

II. Immature children:

A. Over-sheltered
B. Difficult to share possessions

III. Children with phobic reactions:

Therapist deals with phobic reactions as they occur (turning out the light, for example).

IV. Effeminate boys:

Participate in normal games for boys

V. Children with pseudo assets:

A. "too good"
B. Obedient and overly-generous

VI. Children with habit disorders:

A. Eating problems
B. Temper tantrums
C. Receive their strivings for independence

VII. Children with conduct disorders

Children deemed unsuitable for play-therapy are those whose behavior may be harmful to others. These children need individual therapy. Following is an outline of the children unsuitable for play-therapy.[3]

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[3] Ibid., p. 24.

Children Unsuitable for Play-Therapy

I. Intense sibling rivalries:

A. Intense hatred toward brothers or sisters.
B. Need individual treatment.

II. Sociopathic children:

A. Act as though they had no conscience
B. Make other children miserable (bullying, etc.)
C. Should not be seen in clinical setting; they need an authoritarian nature such as in institutions.

III. Children with accelerated sexual drives:

Need individual therapy

IV. Children who steal:

May initiate other children into the art of thievery

V. Children exposed to perverse sexual experiences

VI. Extremely aggressive children:

A. Stems from homicidal tendencies
B. Cannot have permissive atmosphere

VII. Gross stress reaction:

A. Exposed to severe trauma (death, fire, etc.)
B. Need prompt individual therapy

The next outline given is a basic discussion of the composition of groups in which a child will be placed. This composition depends greatly on the harmonious combination of patients.[4]

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[4]Ibid., p. 29.

Composition of Groups

I. Corrective identifications:

A. Corrective influence on each other
B. Associate with personalities different from and complementary to his own

II. Relief from ridicule:

A. Must be a haven from persecution
B. Freedom from fear

III. Optimal tension:

Several quiet children and not more than two who are aggressive

IV. Wrong heroes:

Delinquents should not be placed in the same group with neurotic children who try to conform to society's standards.

V. Neutralizers:

In a lively play group should be one whose behavior is controlled.

VI. Group size:

Should not exceed five

VII. Age:

Should not exceed each others age by more than a year

VIII. Intelligence:

A. Not too important
B. Use the same toys

IX. Open or closed groups:

Good and bad points depending on who is involved. Drop out and adding

X. Mixed Company

Yes.

The play activities are watched and encouraged for this is a very important phase of a child's relationship to others. The medium of play can bare innermost thought, deepest strivings, and conflicts of a tormented being. Play gives the child a freedom of expression. In this way a child may obtain an understanding and insight to the nature of his thinking and behavior.

There are desirable physical dimensions for the play rooms used in group therapy. Too small of an area forces children to be in too close proximity with other children and with the therapists, which causes frustration and irritation. It intensifies defenses and hostility and causes isolated children to withdraw further into themselves and aggressive children to attack others.

Too large an area causes wild running and rough play in aggressive children. It permits withdrawn children to avoid contact with the therapist and other group members.

Play-therapy is done in two types of areas which are related to the age of the children involved. A play room is used for children from the age of three to nine. The two sizes are the individual play-therapy area, of approximately 150 to 200 square feet, and the group play-therapy of 300 to 400 square feet.

For children of between the age of 9 to 13 an activity room is used because at this age they have difficulty in communicating emotional conflicts either verbally or through minature toys. The size of this room is approximately 600 square feet.

SCHOOL

Because of the emotional state of most of these children, many cannot tolerate a full day of school. Those that can go for half a day will leave the grounds and go to a nearby public school. Those who cannot tolerate even this much will be taught in small class rooms of about six persons per class. The length of the school day for any child may be from one hour or much longer, depending on the individual child's ability to cope with the situation.

The teacher is an integral part of the therapeutic team, working closely with the psychotherapist, case worker, unit leaders and group workers.

PROPOSAL

PROPOSED CHILDREN"S PSYCHIATRIC CLINIC AND RESIDENTIAL TREATMENT CENTER FOR AMARILLO, TEXAS

This center would be associated with the present Children's Psychiatric Center in Amarillo, Texas. It will be a private institution for the treatment of children with emotional problems. All admissions will be voluntary. The psychiatric clinic and residential treatment center will be the local community's contribution toward the solution of the nation's number one health problem: mental illness.

The hypothetical client will be the Killgore Children's Psychiatric Center and Hospital, Inc. It will be privately owned and operated, financed by a generous donation by the Killgore Foundation and Hill-Burton matching the funds.

The center will be based on the three major programs of treatment: the out-patient program; the day-patient program; also the residential treatment program.

The out-patient department will accept children up to the age of fifteen for individual therapy with a psychiatrist or psychologist.

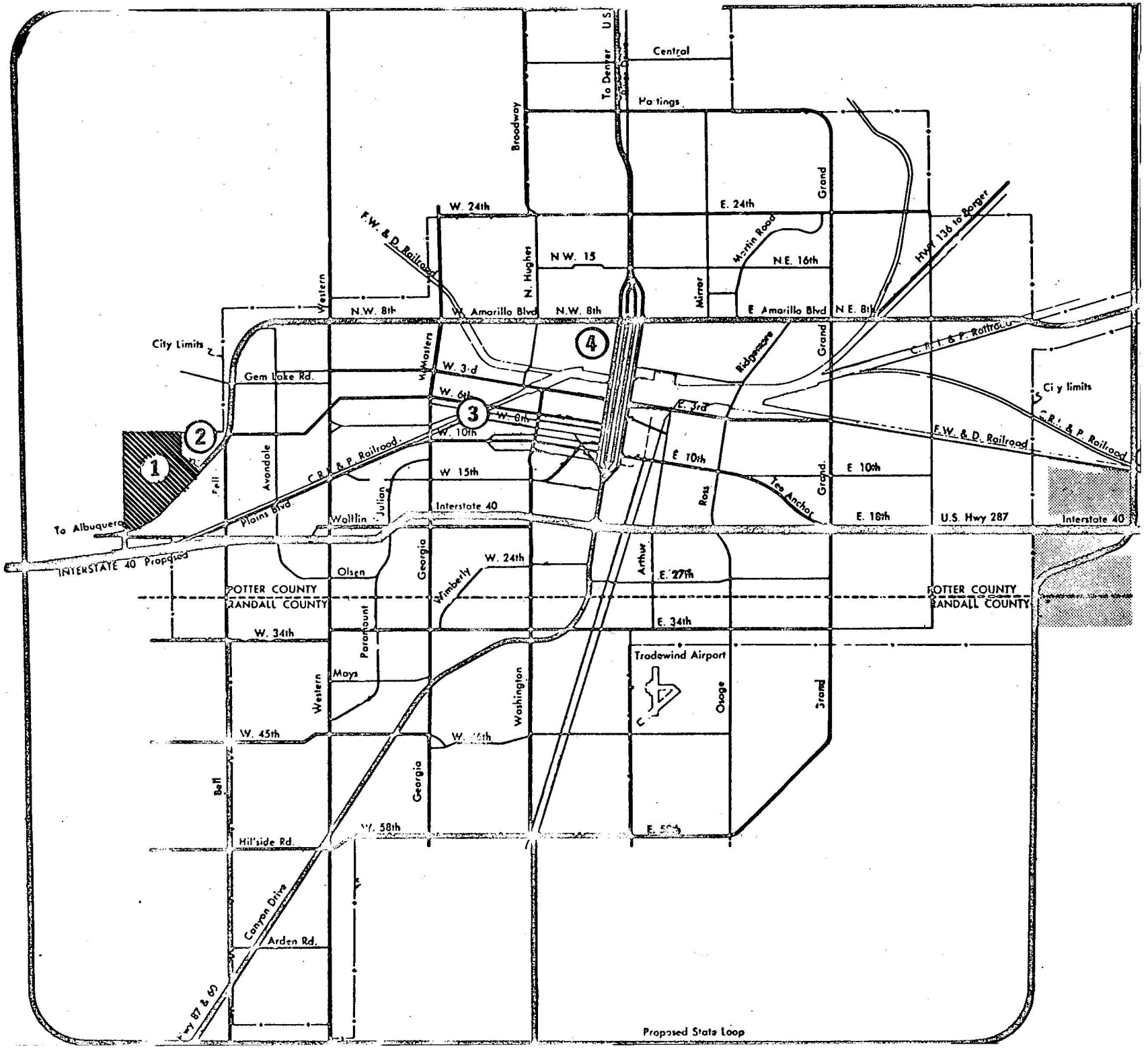
The day-patient department will accept children from four to twelve years of age. The children will remain at the clinic for various periods of time from one hour to a full day. The children will be grouped in a number of ways and will be cared for under social workers and at times a play therapist. A child's actions will be observed and valid experiences will be recorded for study. These observations will assist the psychiatrist in selecting a treatment for the child.

The residential treatment program of the center will also accept only children from the age of four to twelve. The number of children accepted will be limited to forty, who will live in groups of ten children per group. There will be four living units housing complete living facilities for ten children each. The residential facility will be further explained in the section of space analysis.

Site Description

The location of the center will be located in the Amarillo Medical Center, Amarillo, Texas. This medical center is a newly developed four hundred and fifteen acre site in the northeast part of Amarillo. The site of the pro-

posed children's center will be on a fourteen acre plot of land adjacent to a proposed city park and small lake. Access to the center will be from Wallace Boulevard, a newly completed road connecting the medical center to U. S. Highway 66.


Central
To Denver
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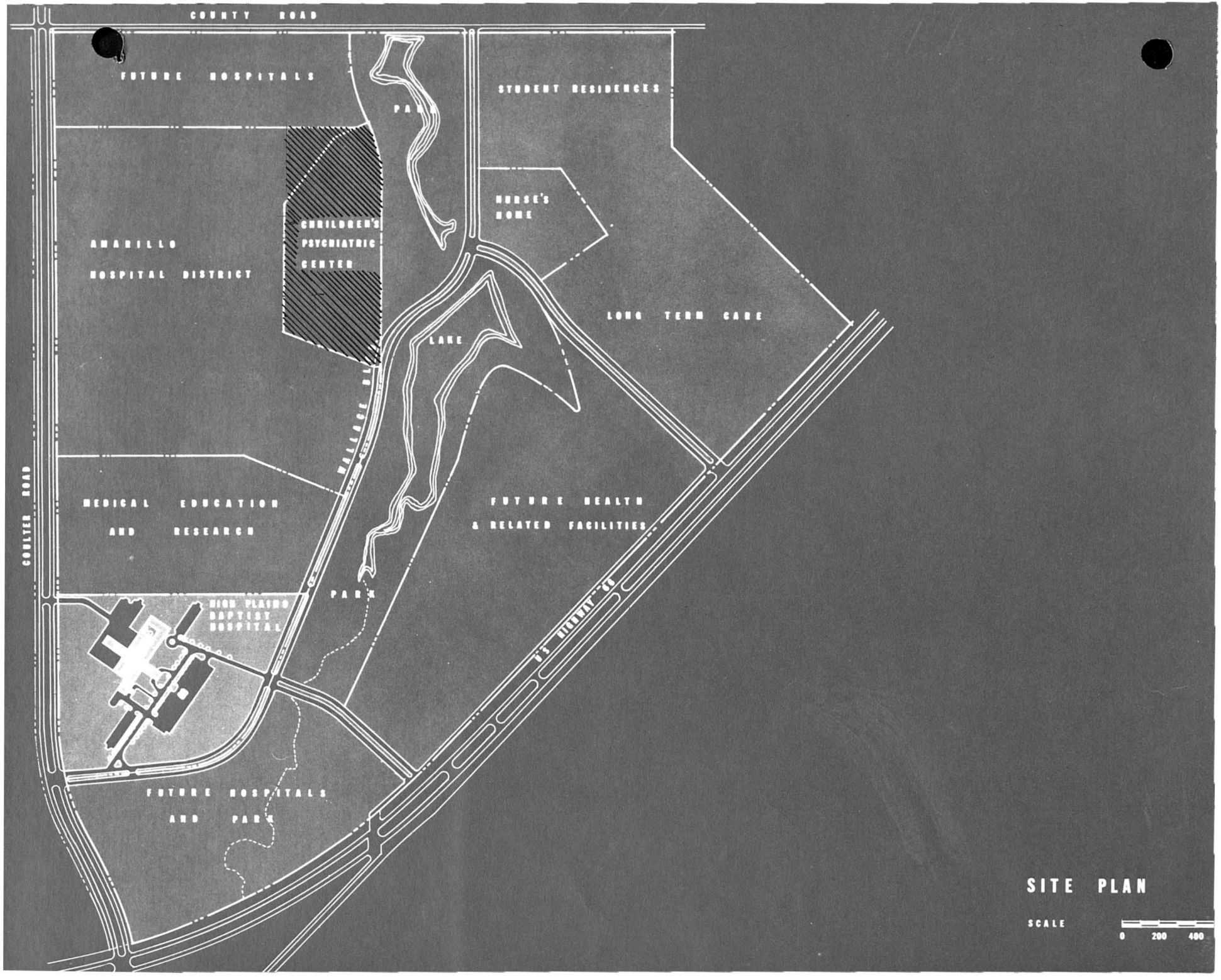
Hastings
Broadway
W. 24th
E. 24th
Grand
F.W. & D. Railroad
N.W. 15
N.E. 16th
Martin Road
Hwy 136 to Borger
Western
N. Hughes
Mirror
N.W. 8th
W. Amarillo Blvd
E. Amarillo Blvd
N.E. 8th
City Limits
Gem Lake Rd.
McMasters
W. 3rd
W. 6th
W. 8th
W. 10th
Ridgecrest
C. R. I. & P. Railroad
City limits
E. 3rd
E. 10th
W. 15th
Avondale
Fell
C.R.I. & P. Railroad
Ross
Tee Anchor
Julian
Interstate 40
U.S. Hwy 287
To Albuquerque
Plains Blvd.
Wolflin
INTERSTATE 40 Proposed
Georgia
Olsen
W. 24th
Wimberly
Arthur
E. 27th
POTTER COUNTY
RANDALL COUNTY
E. 34th
W. 34th
Paramount
Tradewind Airport
Mays
Western
Washington
Osage
Grand
W. 45th
Bell
Hillside Rd.
W. 58th
E. 58th
Canyon Drive
Arden Rd.
Hwy 87 & 60
Proposed State Loop


COUNTY ROAD
FUTURE HOSPITALS
PARK
STUDENT RESIDENCES
NURSE'S HOME
CHILDREN'S PSYCHIATRIC CENTER
AMARILLO HOSPITAL DISTRICT
LONG TERM CARE
LAKE
COULTER ROAD
MEDICAL EDUCATION AND RESEARCH
FUTURE HEALTH & RELATED FACILITIES
PARK
HIGH PLAINS BAPTIST HOSPITAL
U.S. HIGHWAY 66
FUTURE HOSPITALS AND PARK
SITE PLAN
SCALE
0
200
400

LIST OF SPACES NEEDED

I. Administration

- A. One director
- B. One assistant director
- C. Clerical staff of three
- D. Conference for 20 people
- E. Receptionist
- F. Public waiting room
- G. Public toilets
- H. Record keeping

II. Clinical Unit

- A. Four clinical directors
- B. Four psychologists
- C. Twelve psychiatric social workers
  1. Two per unit
  2. Two out-patient
  3. Two in-patient
- D. Conference room for ten
- E. Library
- F. Toilets
- G. Lounge
- H. Receptionists
- I. Waiting room

III. Educational Unit

- A. Four classrooms (two make small auditorium)
- B. One individual play-therapy, ages 3-9
- C. One group play-therapy, (play room, for ages 3-9)
- D. One activity room (for ages 9-13)
- E. Office for play therapists
- F. Storage
- G. Toilets

IV. Observation Rooms

A. Two rooms, four people per room
B. Placed adjacent to play-therapy rooms

V. Infirmary

A. Located close to residential unit
B. Nurses office

VI. Residential units

A. For forty patients (ten per unit)
B. Space for night staff (one per unit)
C. Bedroom (double) minimum of 170 square feet, (five per unit)
D. Each unit should have a living room, dining room, and day room.
E. Toilet facilities per unit

VII. Food service

A. Central kitchen providing food for all four units
B. Food sent to kitchenette in nurses space
C. Office for dietician

VIII. Service

A. Laundry--picked up and delivered
B. Food service
C. Garbage
D. Supplies

SOLUTION

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Correspondence

Sonia Shankman Orthogenic School

Children's Psychiatric Hospital, Ann Arbor, Mich.

Virginia Treatment Center for Children

Child Psychiatric Unit of the Massachusetts Mental Health Center

National Institute of Mental Health

Evansville State Psychiatric Treatment Center for Children

Texas Department of Health

U. S. Department of Health, Education and Welfare.

The Meninger Foundation

Indiana Department of Mental Health

Emma Pendelton Bradley Hospital

Interviews

Mr. Emmett R. Johnson, Executive Director, Amarillo Area Foundation, Amarillo, Texas

Dr. Jamie Quintanilla, Director, The Children's Psychiatric Center, Inc., Amarillo, Texas

Dr. Bob Ray, Department of Psychology, Texas Technological College, March 1966